STATE OF DELAWARE
Child Death, Near Death and Stillbirth Commission
900 King Street
Wilmington, DE 19801-3341

CAPTA[1] REPORT

In the Matter of
Caitlyn Thomas
Minor Child[2]

9-03-2009-00017

September 14, 2012

[1] The federal Child Abuse Prevention and Treatment Act requires the disclosure of facts and circumstances related to a child's near death or death. 42 U.S.C § 5106 a(b)(2)(A)(x). See also, 31 Del.C. § 323 (a).
[2] To protect the confidentiality of the family, case workers, and other child protection professionals, pseudonyms have been assigned.

Background and Acknowledgements

The Child Death, Near Death and Stillbirth Commission ("CDNDSC") was statutorily created in 1995 after a pilot project showed the effectiveness of such a review process for preventing future child deaths. The mission of CDNDSC is to safeguard the health and safety of all Delaware children as set forth in 31 Del.C., Ch., 3.

Multi-disciplinary Review Panels meet monthly and conduct a retrospective review of the history and circumstances surrounding each child's death or near death and determine whether system recommendations are necessary to prevent future deaths or near deaths. The process brings professionals and experts from a variety of disciplines together to conduct in-depth case reviews, create multi-faceted recommendations to improve systems and encourage interagency collaboration to end the mortality of children in Delaware.

Summary of Incident

The case regarding Caitlyn Thomas is considered a near death incident due to physical abuse resulting from head trauma. At the time of the near death incident Caitlyn was approximately one day of age and residing with mother in the hospital.

While residing in the birthing hospital, Caitlyn presented with marked head swelling in January of 2008. When questioned by the nurses and the pediatrician, mother mentioned no injury to the infant; only that she had stumbled while getting out of bed with the infant and fell back onto the hospital cart, hitting her (mother's) wrist. Over the course of the next few hours, mother stuck to her story, but also mentioned several times that she made sure it was documented that she asked for a pain reliever for her injured wrist. The infant suffered from bilateral parietal fractures as well as subdural hematomas. The Division of Family Services and law enforcement were contacted. Law enforcement did not interview the pediatrician as they thought the infant's injuries were accidental and out of their realm of expertise. The infant was transferred to a children's hospital for further evaluation and treatment where a neonatologist, neurologist, and neurosurgeon care for the infant. After further review, the Child Abuse Expert of Delaware felt that it was possible that the infant's injury could have happened accidentally and according to mother's story. However, the Child Abuse Expert in Delaware was shocked and concerned to learn that the infant was discharged home to the care of mother and father.

Mother has no prior history with the Department of Services for Children, Youth and Their Families (DSCYF). An investigation was opened with the Division of Family Services regarding the injuries to Caitlyn. However, based on the findings obtained throughout the investigation, mother was not substantiated. The case was transferred to treatment with concerns regarding mother's lack of reporting and lying about how the infant sustained her injuries. A safety plan was implemented and it was determined that mother was not to be left alone with the infant until treatment was deemed not necessary. Parent Aid services were also recommended and one visit occurred post injury.

Father has history with DSCYF. Father has been the alleged perpetrator in three DFS investigations. However, two investigations were due to abandonment/neglect issues and were unfounded (2001-2002). Father was arrested and placed in the Stevenson House due to unlawful sexual intercourse and sexual exploitation of a minor. He was adjudicated in April of 2002.

System Recommendations

After review of the facts and findings of this case, the Panel determined that all systems did meet the current standards of practice and therefore no system recommendations were put forth.